

Cardiology Consult Request	
First Available Physician	<input type="checkbox"/>
Consult if positive/abnormal test	<input type="checkbox"/>
Dr. Indra Warren <i>MD, FRCPC</i>	<input type="checkbox"/>
Dr. Paul Hong <i>MBChB, FRCPC, MRCP(UK)</i>	<input type="checkbox"/>
Dr. Waseem Hindieh <i>MD, FRCPC</i>	<input type="checkbox"/>
Dr. Mina Girgis <i>MD, FRCPC</i>	<input type="checkbox"/>
Dr. Philippe Beaudry <i>MD, FRCPC, FACC, FASE</i>	<input type="checkbox"/>

Patient Information	
Name:	_____
Date of Birth:	_____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F
Address:	_____ _____
City:	_____ Postal Code: _____
Home Phone:	_____ Cell Phone: _____
OHIP Number:	_____ Version code: _____

Urgency Level
<input type="checkbox"/> Urgent (< 1 week) <input type="checkbox"/> Semi-Urgent (1-2 weeks) <input type="checkbox"/> Routine

Reason for Referral / Past Medical Hx / Current Medications
Please attach previous imaging reports, ECGs, and most recent bloodwork with requisition

Cardiology Testing
<input type="checkbox"/> 12-Lead ECG
<input type="checkbox"/> Exercise Stress Test (GXT)
<input type="checkbox"/> Adult Echocardiogram (TTE)
<input type="checkbox"/> with Contrast
<input type="checkbox"/> Adult Stress Echocardiogram
<input type="checkbox"/> with Contrast
Patch Holter Monitor:
<input type="checkbox"/> 48-hr <input type="checkbox"/> 7-day
<input type="checkbox"/> 72-hr <input type="checkbox"/> 14-day
<input type="checkbox"/> 24-hr Ambulatory BP Monitor
**not covered by OHIP - \$60.00 fee

Referring Physician
Name: _____
Address: _____
Phone #: _____ Fax #: _____
Signature: _____ Billing #: _____
CC: _____ Date of Referral: _____

For additional information and patient instructions, please visit www.medisen.ca